PROVIDER AGREEMENT

State Form 51396 (7-03)
Indiana State Department of Health

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a Provider in Indiana State Department of Health (ISDH) Programs. As an enrolled Provider in ISDH Programs, the undersigned entity agrees to provide ISDH Program-covered services and/or supplies to ISDH participants. As a condition of enrollment, Provider agrees to the following:

1. To comply with all federal and state statutes and regulations pertaining to ISDH Programs, as they may be amended from time to time.

2. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements.

3. To notify ISDH within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.

4. To give written notice to ISDH by completion of "Billing Provider Update Form", at least sixty (60) days before the effective date of the change for any of the following: name (legal name), DBA (doing business as), name as registered with the Secretary of State, address (service location), pay to, mail to, or home office address, Federal tax ID number(s), or change in providers direct or indirect ownership, interest or controlling interest.

5. To provide ISDH Program-covered services and/or supplies pursuant to all applicable Federal and State statutes and regulations.

6. To safeguard information about ISDH Program participants including at a minimum:

   a. name, address, and social and economic circumstances;
   b. medical services provided;
   c. medical data, including diagnosis and past history of disease or disability;
   d. any information received in connection with the identification of legally liable third party resources.

7. To release information about ISDH Program participants only to the ISDH, only when in connection with payment issues surrounding providing services for participants.

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility to assure that all activities under this contract are carried out.

9. To submit claims for services rendered by the Provider or employees of the provider and not to submit claims for services rendered by contractors unless the Provider is a health care facility (such as hospital, ICF-MR, or nursing home), or a government agency with a contract that meets the requirements described in Item 8 of this Agreement. Health care facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide ISDH Program services rendered pursuant to this Agreement.

10. To abide by the ISDH Program Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the ISDH Program Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with ISDH.

11. To submit timely billing in arrears on ISDH approved claim forms or electronically via Electronic Data Interchange (EDI), as outlined in the ISDH Program Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

12. To authorize in writing the direct deposit by electronic funds transfer of all payments from the State of Indiana.

13. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

14. To submit claim(s) for ISDH reimbursement only after first exhausting all other sources of reimbursement as required by the ISDH Provider Manual, bulletins, and banner pages.

15. To submit claim(s) for ISDH reimbursement utilizing the appropriate claim forms and codes as specified in the ISDH Provider Manual, bulletins and notices.

16. To submit claims that can be documented by Provider as being strictly for:

a. medically necessary medical assistance services;
b. medical assistance services actually provided to the person in whose name the claim is being made; and
c. compensation that Provider is legally entitled to receive.

17. To accept payment as payment in full, the amounts determined by ISDH as the appropriate payment, for ISDH Program covered services provided to ISDH Program participants. Provider agrees not to bill participants, or any member of a participant's family, for any additional charge for ISDH Program covered services.

18. The Provider hereby agrees to remove from collections any participant that has been wrongfully identified as delinquent within 5 business days of notice from ISDH.

19. To refund within fifteen (15) days of receipt, to ISDH any duplicate or erroneous payment received.

20. To make repayments to ISDH, or arrange to have future payments from the ISDH withheld, within sixty (60) days of receipt of notice from ISDH that an investigation or audit has determined that an overpayment to Provider has been made. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.

21. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

22. Obtain Prior Authorization for certain designated services for participants of various Programs of the ISDH. Failure to obtain a Prior Authorization, when required, will result in denial of payment and the participant/family may not be billed for the unauthorized services. A Prior Authorization confirms medical necessity and its relationship to an eligible medical diagnosis, but is not a guarantee of payment. Non-emergency designated services should not be provided until Prior Authorization approval is received from ISDH. Charges for services provided while their Prior Authorization determination is pending, will be the provider responsibility, in the event that authorization is denied by ISDH.

23. To cease any conduct that ISDH or its representative deems to be abusive of the ISDH Program.

24. To promptly correct deficiencies in Provider's operations upon request by ISDH.

25 .To cooperate with ISDH or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

26. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex, religion or sexual orientation, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a ISDH Program-covered service.

27. To abide by and agree to the terms and conditions set out in Schedule A (Certification Statement for Providers Submitting Claims), which is incorporated herein by reference.

28. To furnish to ISDH or its agent, as a prerequisite to the effectiveness of this Agreement, the information set out in Schedules B and C to this Agreement, which are incorporated herein by reference, and to update this information, when it changes.

29. To abide by and agree to the terms and conditions set out in the various addenda applicable to the ISDH Programs, with which the provider participates, which are incorporated herein by reference.

30. That this Agreement may be terminated as follows:
a. By ISDH for Provider's breach of any provision of this Agreement as determined by ISDH; or
b. By ISDH, or by Provider, upon thirty day (30) written notice.

31. That this Agreement has not been altered, and upon execution by provider & approval by ISDH, supersedes and replaces any Provider Agreement previously executed with ISDH, by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

FURTHER, THE UNDERSIGNED HEREBY BINDS ALL SUCCESSORS, ASSOCIATES AND ASSIGNEES TO THE STIPULATIONS SET FORTH IN THIS AGREEMENT.

Provider-Authorized Signature – All Schedules

NOTE - The owner or an authorized officer of the business entity must complete this section.

I certify, under penalty of law, that the information stated in Schedules B and C is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana State Department of Health Programs.

Provider DBA Name_____

Officer Name _____ Title _____

Signature _____ Date _____

Telephone Number _____

NOTE: Failure to complete this section will result in ISDH returning the application for incomplete information.

PROVIDER AGREEMENT
Children's Special Health Care Services (CSHCS) Program Addendum
State Form 51398 (7-03)
Indiana State Department of Health

Acknowledgement of Participation

- Payment will be based upon the Medicaid rate, in accordance with state statutes and regulations. Payment as determined by the CSHCS Program shall be accepted as payment in full. Balances cannot be billed to the family.
- Authorization of emergency services must be requested within five (5) days of services being provided
- CSHCS must be billed for all services provided to participants and participant/family may not be billed directly.

Having elected to participate within the Children's Special Health Care Services (CSHCS) Program, I acknowledge the above addendum relating to the CSHCS Program.

Provider DBA Name_____ Tax ID _____

Officer Name _____ Title _____

Signature _____Date_____

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Indiana State Department of Health (ISDH) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the ISDH is acting as my representative and not that of ISDH. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of ISDH claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable federal and/or state law. The provider will hold harmless and indemnify ISDH from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of ISDH billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of ISDH.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with federal and state law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of ISDH Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by the ISDH.

I further certify that no supplemental charges will be billed to any ISDH Programs member or to the family of any member for any covered service of the ISDH Programs.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the ISDH Programs, and to furnish such information regarding any ISDH payments claimed for providing such services to ISDH or its designee, upon request, for a period not less than three years from the date of service, or any such period ISDH may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by ISDH. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to ISDH for claims payment, to document the accuracy of the service for which I have billed the ISDH Programs. I agree to submit such records as may be required by ISDH or the federal government.

I agree to notify ISDH of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission, as may be required by ISDH.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the event that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

Billing Provider Enrollment Application

Indiana State Department of Health

Provider Agreement – Schedule B

Provider Information

1. Provider Type and Specialty

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and. specialty. **Refer to ISDH Billing Provider Specialty List to determine the provider type and specialty numbers for your primary and secondary specialty.** **Taxonomy Codes:** (When mandated.)

Provider Type _____ _____

Primary Specialty _____ _____

Secondary Specialty _____ _____

Primary Sub-Specialty _____ _____

Secondary Sub-Specialty _____ _____

NOTE: You may select only one provider type. If you want to enroll more than one provider type, a separate application must be completed for each provider type. Primary and secondary specialties must be listed under the same provider type on the Billing Provider Specialty List.

2. Which of the following best describes this service location?

Please indicate the choice that best describes the provider location being enrolled. Only one choice may be checked.

__ Individual Practice __ Group Practice __ Facility or Organization Other _____

Note: For Provider Agreements covering more than one individual, please complete the attachment "Individuals Covered Under Provider Agreement".

3. Locality

Please check the locality that best describes the service location. Please check **only one** item.

__ Metropolitan __ Rural __ Urban

4. Service Location Name and Address

Please complete the Provider Name, DBA Name, County, Telephone Number, Address, and the nine-digit ZIP Code for the site where services will be performed. You must complete a separate application for each location where services are performed, even if you bill claims from all locations under one provider number. Except for Sole proprietors who are registered with the County Recorder or use his or her own legal names for business purposes, each service location name must be the Doing Business As (DBA) name registered with the Secretary of State. The address must be a physical location. A post office box is not a valid service location address.

Are you registered with the Secretary of State? __ Yes __ No

Provider Name: _____ County: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

5. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of this service location. The legal name must be the current name on tax, corporation, and other legal documents, and currently registered with the Secretary of State. The address must be a physical location. A post office box is not a valid home office address. If there is more than one legal name currently used by this business entity, attach an explanation listing each name, address, and tax ID number.

Legal Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

6. Mailing Name and Address

Please complete the information for the addressing of bulletins, provider manual updates, and general correspondence, **if different from the Service Location information**. A post office box is acceptable for a mailing address.

Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

7. Pay To Name and Address

Please complete the information for the addressing of checks, remittance advices, and general claims payment information, **if different from the Service Location information**. A post office box is acceptable for this address.

Name: _____

Street Address: _____

City: _____ State: _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

8. Billing Agent

(If you would have us contact your Billing Agent with questions concerning billing issues, please provide the following information.)

Name: _____

Street Address: _____

City: _____ State _____ Zip + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

9. **Federal Tax Identification Number:** _____ Effective Date: _____

National Provider Identification Number (NPI) _____ **Taxonomy Codes**_____

Attach Copy of NPI Notification correspondence

Important: Sections 10-14 require copies of the following documents for verification, as applicable.

- ☐ **Practitioner License from Licensing Board**
- ☐ **Clinical Laboratory Improvement Amendment (CLIA) Certificate**
- ☐ **Federal Drug Enforcement Administration (DEA) Certificate**
- ☐ **Medicare Provider Number Assignment Letter for Medicare Participation**

10. License/Registration/Certification

License/Registration/Certification Number: _____ Issuing Board: _____

Effective Date: _____ Expiration Date: _____

NOTE: A copy of the license from the appropriate licensing board must be attached to the application. Failure to attach a copy of the license will result in ISDH returning this application for incomplete information.

11. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate.

Certification Type:

CLIA Number: _____ __ Waiver

Effective Date: _____ __ Provider-Performed Microscopy Procedure (PPMP)

Expiration Date: _____ __ Registration

__ Compliance

__ Accreditation

NOTE: A Copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

12. Federal DEA Certification

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

DEA Number: _____

Effective Date: _____ Expiration Date: _____

NOTE: A copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for prescriptions you prescribe.

13. Medicaid Participation

Indiana Medicaid Number: _____ Effective Date: _____

14. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number: _____ Medicare Number State: _____

Universal Provider Identification Number (UPIN): _____

DME Supplier Number: _____

Billing Provider Enrollment Application

Indiana State Department of Health

Provider Agreement – Schedule C

Ownership Information

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** item.

__ For Profit Corporation __ Partnership __ Sole Proprietorship

__ Not-for-Profit Corporation __ Government Owned

2. Is this entity chain affiliated?

If yes, the information regarding the chain must be included in **Item 4** below.

__ Yes __ No

3. Is this entity operated by a management company, or leased in whole or part by another Organization?

__ Yes __ No

4. List all owners and officers of the business entity

List below the Name, Title, Social Security Number, and Address of each Officer, owner, and / or trustee of the provider entity, and the Name, Tax ID (TIN), and Address of any organization, corporation, or entity having direct or indirect ownership or controlling interest in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4
Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4
Name	Tax ID Number	Address
Relationship or Title		City, State, Zip + 4

5. **Has there been a change in ownership or control within the past year, or is a change of ownership anticipated?**

If yes, you must submit the enclosed CHANGE OF OWNERSHIP ADDENDUM form for the current provider entity, and a new application for the new ownership entity.

__ Yes __ No

6. **Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?**

__ Yes __ No If yes, when? _____

7. **Background Information**

Has any agent, managing employee, or owner of the provider entity been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX or ISDH program since the inception of those programs?

__ Yes __ No

If yes, state below the Name, SSN, and position within the provider entity:

_____

_____

_____

_____

_____

Billing Provider Specialty List

Please review the list to find the primary and secondary specialty that best describes the service location being enrolled and record the specialty numbers in the appropriate fields in Schedule A, item 7.

Note: A secondary specialty may be designated only if it is included in the same provider type as the primary specialty.

If you are an **INTERNIST** or **PEDIATRICIAN,** please also record your applicable subspecialty from the list in the space provided. If you do not have a subspecialty in these two categories, please choose **GENERAL INTERNIST (Specialty 344)** or **GENERAL PEDIATRICIAN (Specialty 345).**

Provider Type	Provider Specialty
01 Hospital	010 Acute Care Hospital 011 Psychiatric Hospital 012 Rehabilitation Hospital
02 Ambulatory Surgical Center	020 Ambulatory Surgical Center
03 Extended Care Center	030 Nursing Home/Nursing Facility 031 Intermediate Care Facility for the Mentally Retarded (ICF/MR) 032 Pediatric Nursing Facility 033 Group Home/Residential Care Facility
04 Rehabilitation Facility	040 Rehabilitation Facility
05 Home Health Agency	050 Home Health Agency
06 Hospice	060 Hospice Agency
08 Clinic	080 Federally Qualified Health Clinic (FQHC) 081 Rural Health Clinic (RHC) 082 Medical Clinic 083 Family Planning Clinic 084 Nurse Practitioner Clinic 085 Title V Clinic 086 Dental Clinic 087 Therapy Clinic
09 Advanced Practice Nurse	090 Pediatric Nurse Practitioner 091 Obstetric Nurse Practitioner 092 Family Nurse Practitioner 093 Nurse Practitioner (Other) 094 Certified Registered Nurse Anesthetist (CRNA) 095 Certified Nurse Midwife
10 Mid-Level Practitioner	100 Physician Assistant 101 Anesthesiology Assistant

Provider Type	Provider Specialty
11 Mental Health Provider	110 Out Patient Mental Health Clinic 111 Community Mental Health Center 112 Psychologist 113 Certified Psychologist 114 Health Service Provider in Psychology (HSPP) 115 Master of Social Work (MSW) 116 Clinical Social Worker 117 Psychiatric Nurse
12 School Corporation	120 School Corporation
13 Public Health Agency	130 County Health Department
14 Podiatrist	140 Podiatrist
15 Chiropractor	150 Chiropractor
16 Nurse	160 Registered Nurse (RN) 161 Licensed Practical Nurse (LPN) 162 Registered Nurse Clinical (RNC)
17 Therapist	170 Physical Therapist 171 Occupational Therapist 172 Respiratory Therapist 173 Speech/Hearing Therapist
18 Optometrist	180 Optometrist
19 Optician	190 Optician
20 Audiologist	200 Audiologist
21 Case Manager	210 Care Coordinator for Pregnant Women 211 HIV Case Manager 213 Targeted Case Manager
22 Hearing Aid Dealer	220 Hearing Aid Dealer
23 Dietitian	230 Registered Dietitian
24 Pharmacy	240 Pharmacy
25 DME/Medical Supply Dealer	250 DME/Medical Supply Dealer
26 Transportation Provider	260 Ambulance 261 Air Ambulance 262 Bus 263 Taxi 264 Common Carrier (Ambulatory) 265 Common Carrier (Non-Ambulatory) 266 Family Member
27 Dentist	270 Endodontist 271 General Dentistry Practitioner 272 Oral Surgeon 273 Orthodontist

Provider Type	Provider Specialty
27 Dentist (continued)	274 Pediatric Dentist
	275 Periodontist
	276 Mobile Dental Van
	277 Prosthesis
28 Laboratory	280 Independent Laboratory
	281 Mobile Laboratory
9 Radiology Provider	290 Freestanding X-Ray Clinic
	291 Mobile X-Ray Clinic
30 End Stage Renal Disease Clinic	300 Freestanding Renal Dialysis Clinic
31 Physician	310 Allergist
	311 Anesthesiologist
	312 Cardiologist
	313 Cardiovascular Surgeon
	314 Dermatologist
	315 Emergency Medicine Practitioner
	316 Family Practitioner
	317 Gastroenterologist
	318 General Practitioner
	319 General Surgeon
	320 Geriatric Practitioner
	321 Hand Surgeon
	322 Internist (with Subspecialty)
	Subspecialty List:
	Adult Critical Care Medicine
	Adolescent Medicine
	323 Neonatologist
	324 Nephrologist
	325 Neurological Surgeon
	326 Neurologist
	327 Nuclear Medicine Practitioner
	328 OB/GYN
	329 Hematologist/Oncologist
	330 Opthalmologist
	331 Orthopedic Surgeon
	332 Otologist, Laryngologist, Rhinologist
	333 Pathologist
	334 Pediatric Surgeon
	335 Pediatrician (with Subspecialty)
	Subspecialty List:
	Adolescent Medicine
	Diagnostic Lab Immunology
	Developmental Pediatrics
	Medical Toxicology
	Neonatal-Perinatal Medicine
	Pediatric Allergy
	Pediatric Cardiology
	Pediatric Critical Care Medicine
	Pediatric Dermatology
	Pediatric Emergency Medicine

Provider Type	Provider Specialty
31 Physician (continued)	335 Pediatrician (with Subspecialty) – (continued) Subspecialty List: Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Physical Medicine & Rehabilitation Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology
	336 Physician Medicine & Rehab Practitioner
	337 Plastic Surgeon
	338 Proctologist
	339 Psychiatrist
	340 Pulmonary Disease Specialist
	341 Radiologist
	342 Thoracic Surgeon
	343 Urologist
	344 General Internist (without Subspecialty)
	345 General Pediatrician (without Subspecialty)
32 Waiver Provider	350 Aged and Disabled Waiver
	351 Autism Waiver
	352 ICF/MR Waiver
	353 OBRA Developmentally Disabled Waiver
	354 Medically Fragile Children's Waiver
	356 Traumatic Brain Injury Waiver

Effective Date	Expiration Date	Provider Type	Individuals Covered Under Provider Agreement

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

Provider Name: _____

Specialty: _____

License/Registration/Certificate Number: _____

Federal DEA Certificate Number: _____

NATIONAL PROVIDER IDENTIFIER (NPI) INFORMATION

State Form 53215 (1-07)
INDIANA STATE DEPARTMENT OF HEALTH (ISDH)
OFFICE OF HIPAA COMPLIANCE (OHC)

1. ***INSTRUCTIONS:***
   a. *NPI Provider Information must be completed for transactions to process in a timely manner.*
   b. *Additional Taxonomy Codes: If necessary list on separate sheet and fax or e-mail with this form.*
      1. *You will find the taxonomy listing at WPC-EDI link: http://www.wpc-edi.com/taxonomy*
      2. *List all your taxonomy codes, on a separate sheet if necessary, that were registered with NPPES.*
   c. *Additional Tax Identification Numbers: If necessary list on separate sheet and fax or e-mail with this form.*
      1. *Include your Provider ID number and NPI number that coincides with this Tax ID number.*
   d. *Provider Contact Information: For ISDH staff to contact provider in case of questions.*
   e. *Method of Delivery: How to send NPI information.*
2. *Providers/Organizations must complete an NPI collection form or use link to report NPI for each Program Provider ID. Remember to include a copy of the National Plan and Provider Enumeration System (NPPES) certification letter or e-mail for each NPI number reported.*
3. *Depending on your Program affiliation your NPI information can be filled in electronically as a Word form, a PDF form or use the link below. Fill in all sections. This form is for covered entity programs only at ISDH.*

PROVIDER NPI INFORMATION

ISDH Program Name: Childrens Special Health Care Services	
Provider Name Doing Business As *(DBA)*	
Service Location Address *(number and street)*	
City, State	ZIP code + 4
Program Provider ID or Provider Code	Tax ID Number *(List additional #'s below)*
NPI Number *(45 CFR Part 162)*	Taxonomy Code *(s)* *(List additional #'s below)*

ADDITIONAL TAXONOMY CODES

ADDITIONAL TAX ID NUMBER

PROVIDER CONTACT INFORMATION

Electronic Organization Representative *(EOR)* Name		
Contact Name		
E-Mail address	Office Phone Number	Fax Number
Miscellaneous Information		

METHOD OF DELIVERY

PDF form: If you received your NPPES confirmation by US mail: Fill out the PDF form electronically, print and fax your credentials you received in the mail from NPPES to the appropriate fax numbers listed below.

Word form: If you received your NPPES confirmation by e-mail: Fill out the Word form electronically. Save the completed form to your desktop or hard drive. E-mail this saved file as an attachment along with the e-mail you received from NPPES to the appropriate e-mail address listed below.

HIV-MSP Link: https://npi.wellpoint.com/npi/online/onlinesubmit.jsp

Fax Number *(PDF)*: *CSHCS – 317-233-1342* *BCCP – 317-233-7775* *HIV-MSP - See link above* *Other – 317-233-8199*	E-Mail *(Word)*: *CSHCS – lwest@isdh.in.gov* *BCCP – shamm@isdh.in.gov* *HIV-MSP - See link above* *Other – rlove@isdh.in.gov*
Questions regarding NPI, send correspondence to: Office of HIPAA Compliance 2 North Meridian Street, 3K Attn: NPI Project Manager Indianapolis, IN 46204-3021	

Indiana Code 4-13-2-14.8, effective July 1, 2005, requires that all payments to providers be made via direct deposit. The attached for m is required in order for us to set up a new provider record and for you to begin billing and receive payment.

If you have any questions, please contact us at 1-800-475-1355, option number 5 for Provider Relations.

☐ Add Deposit ☐ Change Deposit ☐ Stop Deposit

State Form 47551 (2/96)
Approved by State Board of Accounts 09/1997

Name of Vendor/Claimant who prepared this Request
Work Number: _____
Name: _____ Home Number: _____

STATE OF INDIANA
AUTOMATED DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Instructions:
1. Requestor will complete first section and have their bank/credit union complete Section 2.
2. The bank/credit union will complete Section 2 and return to the requestor.
3. Requestor will file completed form with Auditor of State, 200 West Washington St., Room 240, Indianapolis, IN 46204-2728
4. Requestor and depository should retain a copy. Additional blank copies are available from Auditor of State. Phone: (317) 232-3300

SECTION 1: REQUEST AND AUTHORIZATION

_____ . _____
Vendor / Claimant as shown on the account — Federal I.D. Number / Social Security Number

_____ . _____
Address (Number and Street, and/or P.O. Box No.) — City, State, and Zip Code (00000-0000)

requests, pursuant to IC 4-8.1-2-7(d), to receive payment*(s)* by means of an electronic transfer of funds, and authorizes the same under the terms stated herein.

It is understood by the undersigned Vendor/Claimant that, if approved, the Auditor of State may authorize the Treasurer of State to: (1) initiate credit (deposits) in various and varying amounts, by electronic transfer of funds through automated clearing house (ACH) processes, to the below listed checking *(demand)* or savings account designated in the depository named below, and, (2) *if necessary*, to initiate debit entries or adjustments ***solely to correct any credit error*** *resulting from a deposit/credit entry that was made under this authorization*. The Vendor/Claimant may revoke or cancel this request and authorization by notifying the Auditor of State in writing at least fifteen (15) days prior. Any change to the account or to a new financial institution will require a new State of Indiana Automated Direct Deposit Authorization Agreement. Failure to timely notify the Auditor of an account change will delay payment.

Name of Depository: _____

Type of Account: ☐ Checking *(Demand)* ☐ Savings

Depository Account Number: _____

_____, 20____ _____
Date — Signature of Vendor / Claimant

SECTION 2: DEPOSITORY'S APPROVAL

The above is satisfactory and the undersigned designated depository agrees to accept such automated deposits.

Name of Depository: _____ **Phone: ( )** _____

Address: _____
(Number and Street, and/or P.O. Box No.) — (City, State, and Zip Code (00000-0000)

_____, 20____ _____
Date — Depository's Authorized Signature

_____ _____
ABA Transit-Routing Number — Title

Substitute Form
State Form 23743(R 07/01)
Approved by State Board of Accounts 2001
Approved by Auditor of State 2001

Taxpayer Identification Number Request

State of Indiana

W-9

DO NOT send to IRS

Print or Type

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SSN RECORDS)
DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE

Return to address below

Trade Name Complete only if doing busines as (D/B/A)

Remit Address

Purchase Order Address- Optional

Check legal entity type and enter 9 digit taxpayer Identification Number (TIN) below:
(SSN = Social Security Number, EIN = Employer Identification Number)

SSN or EIN must be for legal name above.

- ☐ **Individual** (Individual's SSN) ___-___-____
- ☐ **Sole Proprietorship** (Owner's SSN or Business EIN) SSN ___-___-____ EIN ___-_____
- ☐ **Partnership** ☐ General ☐ Limited (Partnership's EIN) ___-_____
- ☐ **Estate / Trust** Note: Show the name and number of the legal trust, or estate, not personal representatives. (Legal Entity's EIN) ___-_____
- ☐ **Other** (Limited Liability Company, Joint Venture, Club, etc) (Entity's EIN) ___-_____
- ☐ **Corporation** Do you provide legal or medical services? ☐ Yes ☐ no (Corp's EIN) ___-_____
- ☐ **Government** (or Government operated entity) (Entity's EIN) ___-_____
- ☐ **Organization Exempt from Tax under Section 501(a)** Do you provide medical services? ☐ Yes ☐ no (Org's EIN) ___-_____
- ☐ Check here if you do not have a SSN or EIN but have applied for one.

Under penalties of perjury, I certify that:

(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup witholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, and acquisition or abandonment of secured property, contribution to an individual retirement arrangement (IRA), and payments other than interest and dividends.)

CERTIFICATION INSTRUCTIONS -You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

THE IRS DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

I am a U.S. person (including a U.S. resident alien).

NAME (Print or Type) _____ TITLE _____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE _____

Agency use only

Agency _____ 1099 ☐ Yes ☐ No Approved by: _____

Electronic Data Interchange (EDI) Trading Partner Profile - Billing Service/Clearinghouse

State Form 51441 (7-03)
Indiana State Department of Health

A provider of services has informed us that they would like to begin doing Electronic Data Interchange (EDI) transactions with the Indiana State Department of Health (ISDH). They have informed us that you are their Business Associate for their EDI transactions. Therefore, in order to begin the process, please complete this document and sign the EDI Trading Partner Agreement. Please return these documents to the address below. EDI will not be available for production submissions until October 16, 2003. Upon receipt of the Trading Partner Profile and Agreement, a member of the ISDH EDI staff will contact you concerning your EDI setup and testing. If you have already submitted a profile and an agreement to the ISDH you do not need to complete these forms again.

Billing Service / Clearinghouse:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

__ **Health Care Claim (837)**
__ **Prior Authorization (278)**
__ **Eligibility Request (270)**
__ **Claim Status Request (276)**
__ **Retail Pharmacy Prior Authorization (NCPDP)**
__ **Retail Pharmacy Claim (NCPDP)**
__ **Retail Pharmacy Eligibility Request (NCPDP)**

Outbound (sent from ISDH to you):

__ **Payment Advice (835)**
__ **Prior Authorization (278)**
__ **Eligibility Request (271)**
__ **Claim Status Request (277)**
__ **Retail Pharmacy Prior Authorization (NCPDP)**
__ **Retail Pharmacy Eligibility Request (NCPDP)**

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper. Outbound transmissions will only be sent with prior authorization from billing provider.

Data Transmission / Retrieval Method

__ **Asynchronous** Dial-up

__ **FTP** via PPP Dial-up Connection

_____ _____
Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:
ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

Electronic Data Interchange (EDI) Trading Partner Profile - Provider

State Form 51401 (7-03)
Indiana State Department of Health

Provider of Service:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Software Vendor (please complete this section if you will be using software, either purchased or developed internally, to transmit transactions directly to ISDH):

_____ Purchased (please complete the information below) ____ Developed in-house (do not complete below)

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

__ **Asynchronous** Dial-up

__ **FTP** via PPP Dial-up Connection

Billing Service, or Clearinghouse Information (please complete this section if you are using a billing service or clearinghouse to submit transactions to the ISDH. Please forward the enclosed Trading Partner Profile-Billing Service/Clearinghouse and Trading Partner Agreement to your intermediary for them to complete):

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

__ **Health Care Claim (837)**
__ **Prior Authorization (278)**
__ **Eligibility Request (270)**
__ **Claim Status Request (276)**
__ **Retail Pharmacy Prior Authorization (NCPDP)**
__ **Retail Pharmacy Claim (NCPDP)**
__ **Retail Pharmacy Eligibility Request (NCPDP)**

Outbound (sent from ISDH to you):

__ **Payment Advice (835)**
__ **Prior Authorization (278)**
__ **Eligibility Request (271)**
__ **Claim Status Request (277)**
__ **Retail Pharmacy Prior Authorization (NCPDP)**
__ **Retail Pharmacy Eligibility Request (NCPDP)**

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

Outbound Transaction Transmission

All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing the outbound transactions indicated to be sent to my intermediary listed on page 1

_____
Provider's Initials

_____ _____
Authorized Signature Date

_____
Title of Authorized Signatory

Remittance Address:
ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

TRADING PARTNER AGREEMENT - Electronic Data Interchange (EDI)

State Form 51402 (7-03)
Indiana State Department of Health

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (EDI) between the Trading Partner listed under the *Signatures* heading in this agreement and the Indiana State Department of Health (ISDH).

A. The Trading Partner agrees:

1. To conform to the requirements for *Administrative Simplification* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects ISDH's HIPAA compliance.
2. That it will promptly notify ISDH of any and all unlawful or unauthorized disclosures of confidential information or protected health information (PHI) that comes to its attention and will cooperate with ISDH in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential or protected health information.
3. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.
4. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, effective on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*
5. That it will establish and maintain procedures and controls so that information concerning ISDH health plan participants, or any information obtained from ISDH, shall not be used by agents, officers, or employees of the trading partner other than for its sole intended purpose.
6. That the information stated in any EDI Trading Partner Profile(s) submitted with this Agreement, or subsequently is correct and complete.
7. That it will allow ISDH 30 days after receipt of written notice from the provider if there is any change in the trading partner representative or location where electronic transactions are sent.
8. That it is bound by written agreement with the provider to comply with state and federal law, if the trading partner is an intermediary for the billing provider.

B. ISDH agrees:

1. To conform to the requirements for *Administrative Simplification* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects the trading partner's HIPAA compliance.
2. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.
3. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, effective on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

C. Both parties agree:

1. That documents will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.
2. That upon receiving any documents, to prepare and transmit a timely response or an acknowledgment of transaction receipt. If acceptance of a document is required, a document is not considered received until an acceptance acknowledgement is returned.
3. To notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.
4. That each party will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.
5. To conduct business and perform as required by this agreement and any applicable rules or regulations.
6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the trading partner or provider is disqualified through a federal administrative action or state action. That any document transmitted according to this agreement will be considered an original and signed when received electronically. Neither party will contest the validity or enforceability of signed documents under any applicable law concerning whether certain agreements must be signed in writing to be binding. Neither party will contest the admissibility of copies of signed documents under the business records exception to the hearsay rule, the best evidence rule, or the basis that the signed documents were not originated in documentary form.
7. That neither party will be liable for any special, incidental, exemplary, or consequential damages resulting from any delay, omission, or error in the electronic transmission or receipt of any document, even if either party has been advised such damages are possible.
8. That both parties will attempt to resolve any issues relating to this agreement.

D. Signature:
I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Trading Partner	Phone Number
Signature Completed by/ Title (Original Signature ONLY)	Address
Date	City /State/ZIP+4

Electronic Data Interchange (EDI) Trading Partner Profile – Provider Change

State Form 51406 (7-03)
Indiana State Department of Health

Provider of Service:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Software Vendor:

____ Purchased (please complete the information below) ____ Developed in-house (do not complete below)

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Change of Billing Service or Clearinghouse Information:

Name: _____

Address (include Suite): _____

City: _____ State: _____ Zip + 4: _____

Contact Name: _____

Phone: _____ Fax: _____

E-Mail: _____

Indicate your request(s) for the EDI transactions below.

Inbound (sent from you to ISDH):

__ Health Care Claim (837)
__ Prior Authorization (278)
__ Eligibility Request (270)
__ Claim Status Request (276)
__ Additional Patient Information (275)
__ Retail Pharmacy Prior Authorization (NCPDP)
__ Retail Pharmacy Claim (NCPDP)
__ Retail Pharmacy Eligibility Request (NCPDP)

Outbound (sent from ISDH to you):

__ Payment Advice (835)
__ Prior Authorization (278)
__ Eligibility Request (271)
__ Claim Status Request (277)
__ Retail Pharmacy Prior Authorization (NCPDP)
__ Retail Pharmacy Eligibility Request (NCPDP)

Remittance Advices are provided on a weekly basis ONLY and include claims submitted electronically and on paper.

Data Transmission / Retrieval Method (please complete if you will be submitting transactions directly from your office to ISDH):

__ **Asynchronous** Dial-up

__ **FTP** via PPP Dial-up Connection

Outbound Transaction Transmission

All outbound transmissions indicated above will be sent to the provider of service. If you want outbound transactions to be sent via a clearinghouse or billing service, please initial below.

I am authorizing all outbound transactions be sent to my intermediary listed above _____
Provider's Initials

_____ _____

Authorized Signature Date

_____

Title of Authorized Signatory

Remittance Address:

ISDH
Office of HIPAA Compliance
EDI Provider Relations, 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803